

# APPLICATION TO REGISTER AS AN INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER OR APPLICATION REQUEST TO CONTINUE INSURANCE COVERAGE Voluntary Health Care Provider Program

ADMINISTRATIVE SERVICES UNIT  
UNIVERSITY PARK PLAZA  
2829 UNIVERSITY AVENUE SE, SUITE 445  
MINNEAPOLIS, MINNESOTA 55414

Phone: 651-201-2732 or Fax: 612-617-2125 or [www.asu.state.mn.us](http://www.asu.state.mn.us)

DATE OF APPLICATION: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

## INSTRUCTIONS FOR INDIVIDUAL VOLUNTEER - REGISTRATION

1. Answer all questions completely and accurately, or the application will be returned.
2. There is no application fee.
3. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action by the individual licensing board if you are subsequently registered by ASU.
4. Incomplete applications may be destroyed after six months of inactivity.
5. Registration expires annually April 30<sup>th</sup>.
6. This program operates under - Minnesota Statute 214.04.
7. Complete this form – Form E. Initially prior to April 1st each year.

## For Office Use Only

Date Received: \_\_\_\_\_  
License #: \_\_\_\_\_  
License Status: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Date Processed: \_\_\_\_\_

Use this form only if you intend to register as an individual volunteer provider and be eligible for liability coverage. You must be listed on the Volunteer Roster, provided to the state of Minnesota by the facility or organization granted authority as a Registered Voluntary Health Care Provider.

New Applicant Registration: ☐ Yes ☐ No

Renewal / Request to continue insurance: ☐ Yes ☐ No

Title	FIRST NAME	MIDDLE NAME	LAST NAME
STREET ADDRESS:			Birth date:
CITY:		STATE OR PROVINCE:	ZIP CODE:
PHONE:	FAX PHONE NUMBER		WEB ADDRESS
Name of clinic or facility registered with where you are providing volunteer service:			EMAIL ADDRESS
Licensed by Board of :	License #:	Birth date:	Licensed in other Jurisdictions:

Licensed as: physician, physician assistant, nurse, dentist, dental hygienist, other: \_\_\_\_\_

**YOU MUST ATTACH A COPY OF YOUR LICENSE/CERTIFICATE!**

I herein make application to be registered as a Health Care Provider for the listed Voluntary Health Care Provider Program, registered with the Administrative Services Unit for the Health Licensing Boards of the State of Minnesota.

1. I agree to receive no direct monetary compensation of any kind for services provided at this facility. ☐ Yes ☐ No

2. My current license is free of restriction in all jurisdictions. ☐ Yes ☐ No

3. Has any disciplinary action been taken against your license by a professional licensing authority or health care facility, including any voluntary surrender of license or other agreement involving the health care providers license to practice or any restrictions on practice, suspension of privileges, or other sanctions? ☐ Yes ☐ No

If yes, provide details below. Attach additional explanation if necessary. \_\_\_\_\_

4. Has any malpractice suit ever been filed against you? ☐ Yes ☐ No

If yes, what was the outcome of the suit filed against you? \_\_\_\_\_  
Please attach information outlining the origination of the suit and the final resolution.

5. If you have been named as a defendant in a law suit, or if any claims have been made against you with a previous or current insurer, give dates, allegations, and disposition of each claim, or suit arising out of any occurrence within the last five years.

\_\_\_\_\_

6. If you have knowledge of any past activities or incidents that might give rise to a claim not yet presented, please explain: \_\_\_\_\_

\_\_\_\_\_

7. How long have you been practicing in each health care or related service activity you preform?

Describe: \_\_\_\_\_ Years/Months: \_\_\_\_\_  
Describe: \_\_\_\_\_ Years/Months: \_\_\_\_\_

8. Type of Practice (Check)

☐ Individual ☐ Professional Corporation ☐ Professional Association ☐ Partnership  
☐ Resident/Intern ☐ Other: \_\_\_\_\_

9. If Employed, Name of Employer: \_\_\_\_\_

10. Are you self-employed? Yes \_\_\_\_\_ No \_\_\_\_\_ Number of hours worked per week? \_\_\_\_\_

Are you employed by others, or partner in a partnership? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate which type: Employed \_\_\_\_\_ Partner \_\_\_\_\_

Give name of employer or partners: \_\_\_\_\_

Show type of health care or related service provided: \_\_\_\_\_

11. Does your employer provide Professional Liability Coverage for you? Yes \_\_\_\_\_ No \_\_\_\_\_

12. Are you an owner, operator, officer, partner, administrator, or have a similar capacity in any health care or related services organization? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, identify and explain: \_\_\_\_\_

13. If you have any independent contractors working for you, please describe, including type and in what capacity independent contractor is working. None: \_\_\_\_\_

14. School of graduation: \_\_\_\_\_

Degree: \_\_\_\_\_ Year: \_\_\_\_\_

a. If a foreign medical school graduate, are you certified by the educational council for foreign medical graduates?

[ ] Yes [ ] No Year Certified: \_\_\_\_\_

b. Name and location internship served: \_\_\_\_\_

c. Name and location residency served: \_\_\_\_\_

15. Name all places where you have practiced your profession in the last five years:

Location:

During Years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. List all states where you are licensed to practice and your license numbers. ATTACH CURRENT COPIES OF ALL LICENSES.

\_\_\_\_\_  
\_\_\_\_\_

17. Are you currently covered by a medical professional liability insurance policy or self-insured plan either personally or through another facility or employer

☐ Yes

☐ No

Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

18. Are you seeking medical professional liability insurance as a volunteer in the above named registered facility or organization?

☐ Yes

☐ No

19. **What date does the insurance coverage need to be effective?**

Date

20. Will you comply with risk management and loss prevention policies imposed by the insurer?

☐ Yes

☐ No

21. What are the number of volunteer hours you anticipate performing?

Starting date: \_\_\_\_\_

Ending date: \_\_\_\_\_

# Hours per month: \_\_\_\_\_

# Hours per year \_\_\_\_\_

The applicant agrees that signing this application does not bind the state to complete the insurance, however, this application will be the basis of the contract should a policy be issued. The applicant certifies that reasonable inquiry has been made to obtain the answers given in this application and that this application has been completed in a true, correct and complete manner to the best of the applicant's knowledge and belief.

Signature \_\_\_\_\_

Date \_\_\_\_\_